Office of the State Employer
Employee Health Management

AUTHORIZATION TO RELEASE CLAIMANT MEDICAL INFORMATION

I, _____, hereby authorize and direct any and all medical providers and facilities to release information contained in my patient records, that may relate to my disability claim filed on _____, and to disclose any such information to authorized representatives of the State of Michigan and its third party disability claims administrator, Citizens Management, Inc. (CMI). The purpose of this disclosure is to provide medical and related documentation in order for my claim for disability benefits to be adequately evaluated.

Medical information to be released specifically includes, but is not limited to, all medical, psychiatric, dental, hospital, clinical, employment, insurance claims and vocational records. This authorization allows the State of Michigan and CMI to release the above-mentioned information and records to each other.

This medical release is valid during the pendency of my claim and shall expire when my claim concludes. This release may be revoked at any time. However, any information already obtained as a result of this release may be used for the purpose of evaluating my disability benefit claim. I understand that the records released for the above purpose will be handled in a confidential manner, and utilized only for the purpose of determining my disability benefits.

A faxed or electronic copy of this medical release and authorization shall be treated as an original valid document. I understand that failure to provide a signed copy of this medical release and authorization may prevent CMI from processing my disability claim.

Applicant Signature: _____ Date: _____

Witness Signature: _____Date: _____

Witness Name: _____
(Please print)

DMB-OSE 2210 12-2012